

**U.S. Department of Health and Human Services (HHS)
National Institutes of Health (NIH)
National Institute on Minority Health and Health Disparities (NIMHD)
National Advisory Council on Minority Health and Health Disparities (NACMHD)**

6707 Democracy Boulevard
Bethesda, MD

**June 11, 2013
8:00 a.m. – 3:38 p.m.**

Meeting Minutes

Council Members Present

John Ruffin, Ph.D., Chair, NACMHD
Jasjit S. Ahluwalia, M.D., M.P.H.
Marjorie Mau, M.D., M.S. (*by teleconference*)
The Honorable Kweisi Mfume
Jesus Ramirez-Valles, Ph.D. (*by teleconference*)
Raj Shah (*by teleconference*)

Ad Hoc Members

Judith Bradford, Ph.D.
Eddie Greene, M.D.
Valerie Montgomery Rice, M.D.
Frank Talamantes, Ph.D.
Linda Thompson-Adams, Ph.D., R.N., FAAN

Ex Officio Members

Michael J. Fine, M.D., M.Sc.
Robert M. Kaplan, Ph.D.

Executive Secretary

Donna A. Brooks

CLOSED SESSION

The first portion of the meeting was closed to the public in accordance with provisions set forth in Sections 552b(c) (4) and 552b(c) (6), Title 5, U.S.C., and Section 10(d) of the Federal Advisory Committee Act, as amended, U.S.C. Appendix 2.

REVIEW OF GRANT APPLICATIONS

Executive Secretary Donna A. Brooks called the Closed Session to order at 8:06 a.m. Dr. John Ruffin, Director of the National Institute on Minority Health and Health Disparities (NIMHD), welcomed the Council members.

Dr. Ruffin led the second level review of grant applications. The Council considered 35 applications requesting an estimated \$17,643,718 in total costs. Applications from the following programs and initiatives were considered: Research Centers in Minority Institutions (RCMI); Clinical Research Education and Career Development in Minority Institutions; Scientific Conference grants; Small Business Innovation Research (SBIR)/Small Business Technology Transfer Research (STTR); Research on the Health of LGBTI Populations; Understanding and Promoting Health Literacy; and Advancing Novel Science in Women's Health Research. All second level review decisions were made through *en bloc* voting.

Ms. Brooks adjourned the Closed Session at 8:45 a.m.

OPEN SESSION

CALL TO ORDER AND WELCOME

Ms. Brooks called to order the Open Session at 9:31 a.m.

OPENING REMARKS AND INTRODUCTIONS

Dr. Ruffin welcomed all participants to the 33rd NACMHD meeting. Some Council members are serving in an *ad hoc* capacity while their appointments are being processed by the Department of Health and Human Services (HHS). Council members introduced themselves and shared updates on their recent activities.

CONSIDERATION OF FEBRUARY 2013 MINUTES

Council members unanimously approved the minutes of the February 26, 2013 meeting.

FUTURE MEETING DATES AND ADMINISTRATIVE MATTERS

NACMHD meetings are scheduled for September 10, 2013 and February 25, 2014.

NIMHD DIRECTOR'S REPORT

Dr. Ruffin presented the NIMHD Director's Report to update the Council on recent activities at NIMHD and across the National Institutes of Health (NIH).

New NIMHD Staff

- Office of the Director: Dr. Toya Randolph and Dr. Pamela Thornton, health science administrators.
- Division of Extramural Research: Dr. Marcia Gomez, health science policy analyst.
- Division of Intramural Research: Ms. Gail Taylor, laboratory operations coordinator.

Dr. M. Roy Wilson, Deputy Director for Strategic Scientific Planning and Program Coordination (SSPPC), is leaving NIMHD to assume the presidency of Wayne State University in August 2013. Dr. Ruffin thanked Dr. Wilson for his leadership and service to NIMHD and wished him well in his new position. Dr. Wilson thanked the Council and NIMHD staff for the opportunity to work together. Dr. Nathaniel Stinson has been appointed Interim Deputy Director for SSPPC, and Dr. Irene Dankwa-Mullan will serve as Interim Director for the Division of Scientific Programs.

NIMHD Program Funding

On March 2, 2013, President Obama signed an Executive Order initiating sequestration in the federal budget. The sequestration requires NIH to cut 5 percent (approximately \$1.55 billion) from its fiscal year (FY) 2013 budget.

After accounting for sequestration, the NIMHD FY 2013 budget is \$260.5 million. The Institute is funding non-competing awards at 93.5 percent with the exception of SBIR awards, which remain at 100 percent funding. The SBIR/STTR Reauthorization Act of 2011 mandated an increase to this set-aside program, which is now taking effect. For competing research grants, NIMHD's goal is to maintain the average size of the awards commensurate with FY 2012 levels, meaning that the Institute will likely support fewer awards. For competing research grants awarded in FY 2013, inflationary increases for out-year commitments will be discontinued. The Council discussed the implications of the sequestration and the probability that the Institute will need to identify and reduce duplication in its programs, while also maintaining those programs that are mandated by law. The NIMHD FY 2013 grant funding policy can be found at: www.nimhd.nih.gov/NIMHD_FY13_Fin_Mgmt_Plan.pdf

As a result of the Council's second level review of grant applications in February 2013, the following awards were made: three scientific conference grants; three SBIR/STTR grants; four Transdisciplinary Collaborative Centers (TCC)—two each in the areas of health policy and men's health; 14 awards for the dissemination phase of the Community-Based Participatory Research Program (CBPR); and 11 new R01 grants.

Current Funding Opportunity Announcements

NIMHD programs currently accepting applications are:

- **NIMHD Technologies for Improving Minority Health and Eliminating Health Disparities (R41/R42)**
Application receipt date: Aug. 7, 2013
- **Limited Competition: NIMHD Research Centers in Minority Institutions Infrastructure for Clinical and Translational Research (RCTR) [U54]**
Application receipt date: Aug. 14, 2013
- **Revision Applications for Basic Social and Behavioral Research on the Social, Cultural, Biological, and Psychological Mechanisms of Stigma (R01)**
Application receipt date: August 2, 2013
- **NIH Scientific Conferences (R13)**
Standard application receipt dates: Aug. 12, 2013
- **Evidence-based Demonstration Projects in Immunization (Admin Supplement)**
Application receipt date: July 10, 2013

At the September 2013 Council meeting, members can expect to conduct second level review of applications from the Minority Health and Health Disparities International Research Training Program (MHIRT), as well as scientific conference grant applications and co-funding initiatives.

NIH received 89 applications for planning grants for the Building Infrastructure Leading to Diversity (BUILD) program and 34 applications for planning grants for the National Research Mentoring Network (NRMN) program. The Council will review those applications in September. Funds for the BUILD and NRMN programs, as well as for the coordination and evaluating center, will be provided by the NIH Common Fund within the NIH Office of the Director. NIMHD is the lead Institute for implementing these programs in cooperation with the National Heart, Lung, and Blood Institute (the co-lead Institute).

NIMHD Intramural Research Program: The Institute has secured space for its intramural investigators on campus in Buildings 3, 10 (the Clinical Center), and 37. Recruitment is ongoing for a deputy director for the intramural program, an adjunct investigator, and a new tenure track investigator.

Strategic Planning: Work is progressing on the 2014-2018 NIH Health Disparities Strategic Plan. When the new Council members are officially cleared, Dr. Ruffin will create a sub-committee to review the draft strategic plan and provide advice to the Institute.

COUNCIL ORIENTATION

NIMHD senior leadership provided an orientation for advisory council members that covered the role of the advisory council, the membership and an overview of the NIMHD.

Advisory Council: Dr. Ruffin reviewed the role of the NACMHD. He noted it is an advisory body to the Secretary, HHS, the NIH Director, and the NIMHD Director. Council members are appointed by the Secretary, HHS. A principal role of the Council is to conduct second level review of grant applications. Membership on the Council includes representation from the scientific community or health professional fields, as well as the general public.

NIMHD History: Dr. Ruffin provided the Council with an overview of the legislative history of the Institute starting with the creation of the Office of Research on Minority Health per the NIH Revitalization Act, the establishment of the National Center on Minority Health and Health Disparities via the Minority Health and Health Disparities Research and Education Act, and finally the redesignation of the NCMHD to the National Institute on Minority Health and Health Disparities as a result of the Patient Protection and Affordable Care Act.

Organizational Structure: NIMHD comprises the Division of Data Management and Scientific Reporting, the Division of Intramural Research, and the Division of Scientific Programs. The NIMHD Office of the Director includes four divisions focused on administrative and financial activities, communications, grant review and management, and strategic planning and legislation.

Strategic Planning: Part of the NIMHD's coordination role is to develop the NIH Health Disparities Strategic Plan and Budget. The plan is developed in collaboration with the other NIH Institutes and Centers, and the NIH Director in consultation with the NACMHD. The plan includes priorities, objectives, measures, a timeline, and a budget.

Extramural Research: Dr. Joyce A. Hunter, deputy director for extramural research activities; Dr. Nathaniel Stinson, and Dr. Francisco Sy, Chief of the Office of Extramural Research Administration (OERA) presented an overview of the NIH extramural research process and the NIMHD extramural research portfolio. In 2013, NIH will distribute about 80 percent of its \$29.2 billion budget in the form of extramural grants, cooperative agreements, and contracts. Funding opportunities are communicated through program announcements (PA), requests for applications (RFA; for grants), and requests for proposals (RFP; for contracts).

The role of the extramural team was discussed. Program staff recommend grants for funding in parallel with recommendations from the Council; perform scientific and administrative management of the Institute's grant portfolio; review progress reports, and write initiatives for new programs. Review staff ensure a fair and objective scientific review of the technical merit of all applications, select panel members for the peer review process, and prepare summary statements. Grants Management staff handle the fiscal and administrative management of grants after awards are made.

The Center for Scientific Review (CSR) is the central receipt site for all NIH grant applications. Approximately 65 percent of all applications are reviewed within CSR. The remaining applications are assigned to an Institute Review Group; applications reviewed within an Institute include those submitted in response to an RFA, clinical trials, center grants, SCOREs, program projects, and contracts.

Finally, the first and second levels of review were discussed, including the role of the advisory council in the second level of review, and the current NIH policy on appeals. The first level of review considers the scientific and technical merit of each application, resulting in a score and a recommendation regarding the level and duration of funding. The second level of review assesses the quality of the review group's recommendations. A grant application score cannot be changed at the second level review; however, a Council can defer an application for re-review. Applicants can appeal a review recommendation after receipt of a summary statement, except in the case of applications submitted in response to an RFA. If program and review staff cannot resolve an applicant's appeal, then the appeal would be submitted to the Council for review. Bases for appeal include evidence of bias, conflicts of interest, or factual error. If the Council accepts an appeal letter, the original application may be sent back for review by the same or a different study section, depending on the reason for the appeal. Final funding decisions are made on the basis of scientific merit, program consideration, and availability of funds.

Council members were provided written information on ethical rules, standards of conduct, and policies on conflicts of interest, confidentiality, and lobbying. Council members must recognize a fine line between lobbying for funding, which is not permitted, and serving in an education role.

Dr. Sy discussed some of the policy issues relevant to extramural research. The pre-award process requires grantees to submit information that may include Institutional Animal Care and Use Committee approval, Institutional Review Board approval, Human Subjects Protection Training Certification, revised budgets, or a data safety monitoring plan. The Notice of Award is a legally binding document that contains award data, other fiscal information, terms and conditions, and any restrictions on use of the funds. After an award is made, progress reports must be submitted annually up to 60 days before a non-competing continuation award is made or 90 days after the project period ends. An annual federal financial report must be submitted electronically, and annual audits are required for grantees who receive more than \$500,000 per year.

Dr. Stinson presented an overview of the NIMHD extramural research program portfolio. The programs are aligned under four general themes:

(1) Transdisciplinary and translational research, which includes the Centers of Excellence (COE) and Transdisciplinary Collaborative Centers (TCC) programs. COEs are required to have a community engagement core. The COE program is divided according to how much funding an institution receives from NIH—institutions with funding below a defined threshold compete for P20 centers and others compete for P60 centers. The TCC program is designed to encourage institutions to work together on a regional level. To date, the TCCs have focused on social determinants of health, policy research, and men's health.

(2) Basic, social, and behavioral research includes support for the CBPR. The dissemination phase for the first cohort from this initiative has begun, and 31 planning grants for the next cycle have been awarded. This theme also supports R01, SBIR/STTR, and conference grants.

(3) Science education and training focus on mentoring and career development. Two loan repayment programs are available for individuals who conduct health disparities research or who have a history of financial disadvantage. The DREAM program allows early stage investigators to work in any NIH intramural program for two years and then return to the extramural community with three years of funding for health disparities research. The Council asked for information on the geographical distribution, race, and ethnicity of participants in the DREAM program.

(4) Research capacity and infrastructure, includes the Research Endowment program and the Building Research Infrastructure and Capacity (BRIC) program for institutions with modest support for research activities. The Resource-Related Health Disparities Research program has four areas that are targeted for investment including bioethics, global health research with a focus on the Caribbean, data infrastructure and information dissemination, and research on healthcare for rural populations. The RCMI program helps build capacity and infrastructure at minority-serving institutions that have a graduate program.

SCIENTIFIC PRESENTATIONS

The Advantages of Co-Location of Academia with the Community: Addressing Health Disparities

Lucile Adams-Campbell, Ph.D., is Associate Director for Minority Health and Health Disparities Research, Associate Dean for Community Health and Outreach, and Professor of Oncology at the Lombardi Comprehensive Cancer Center at Georgetown University Medical Center. Dr. Adams-Campbell spoke about health disparities research and outreach at Georgetown.

Dr. Adams-Campbell's goal is to apply the resources of the Cancer Center to address the biological and social determinants of cancer health disparities in partnership with the local Washington, DC metropolitan community. Her strategy includes increasing the cadre of health disparities researchers; establishing community-based partners and partnerships; engaging in community outreach with evidence-based science; supporting clinical trials in the community; increasing programmatic collaborations; and disseminating research findings to the community.

Dr. Adams-Campbell conducted a SWOT analysis of the environment for health disparities research at Georgetown. Strengths include a community advisory board comprising business partners, public housing community residents, and academics, as well as the designation of all of Washington, DC as a major catchment area. Weaknesses include the challenge of engaging more people, the need for new mid-level faculty, and the need to increase the number of high-impact publications. An important opportunity is the ability to focus on the biological basis of disparities as a means to bridge the gap between basic population and clinical sciences. In addition, the Clinical and Translational Science award provides an opportunity for investigators to engage in team science projects that have the potential for high impact. The Capital Breast Care Center (CBCC) is another critical opportunity. The CBCC is an outreach arm of the Cancer Center that provides mammography screening services for the poor and underserved. Each year, the CBCC screens 1,500 to 1,800 women, of whom 48 percent are African American and 45 percent are Hispanic.

Dr. Adams-Campbell described several initiatives related to health disparities that are supported by Georgetown, including:

- Quit & Fit is a program to encourage healthy behaviors related to exercise and smoking.
- The Environmental Justice Advisory Committee was formed in response to the community's interest in addressing environmental justice issues in the inner city region of DC.
- An Office of Minority Health and Health Disparities was opened in southeast DC.
- The HOYA Clinic at the former DC General Hospital building is run by Georgetown medical students to provide care to the poor and homeless population. An HPV educational program, which is funded by a K award from NIMHD, is conducted at the HOYA Clinic to educate parents on the mandate for HPV vaccination in DC.
- Another study funded through a Centers of Excellence in Health Disparities grant focuses on African American women with metabolic syndrome and high risk of breast cancer.
- The Focused Intervention Exercise to Reduce Cancer (FIERCE) study compares the impact of exercising in a designated facility to exercising at home on obesity, metabolic syndrome, and known breast cancer markers in post-menopausal African American women who are at increased risk of breast cancer.

- **Minority Health Matters** is a program with a calendar of activities for the community that focuses on churches.

Dr. Adams-Campbell has changed the culture at Georgetown in a short time, engaging both the Cancer Center and the university as a whole in health disparities research. The university now views health disparities as a priority focus area and actively raises development funds to support relevant programs.

Georgetown scientists are tackling a number of scientific questions related to health disparities, such as triple negative breast cancer, the biological basis of obesity and its impact on other chronic diseases, mammography adherence, the role of vitamin D in cancer health disparities, and the impact of nutrition on cancer prevention.

Tracking Disparities in the National Healthcare Reports

Ernest Moy, M.D., M.P.H., is a Medical Officer in the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality (AHRQ). Dr. Moy gave a presentation on two annual reports that AHRQ provides to Congress—the National Healthcare Quality Report and National Healthcare Disparities Report. The latest reports, which cover data from 2012, were released in May 2013.

The AHRQ mission is to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans. The agency seeks to affect change through the healthcare delivery system with a commitment to addressing equity and disparities. AHRQ's core functions include research to improve the healthcare system, conducting meta-analyses of published literature to summarize state-of-the-art interventions and disseminating the findings, and working with communities and partners to help Americans care for themselves.

The National Quality Strategy is an HHS-wide activity led by AHRQ. Six priorities are patient safety, person and family engagement, communication and coordination of care, effective prevention and treatment, starting with cardiovascular disease, supporting healthy living and lifestyle modification, and making healthcare more affordable. AHRQ is developing metrics for each priority, which will be implemented through agency-wide plans.

The national healthcare reports are required by the AHRQ reauthorizing legislation of 1999 and the Minority Act of 2000. The first reports were produced in 2003. One team produces both reports with support from an interagency working group that comprises members from agencies across HHS. The reports utilize a single conceptual framework, as well as the same data, methods, and measures. Although the reports focus on different topics, AHRQ determined that healthcare quality cannot be understood without understanding disparities and vice versa.

The quality report focuses on traditional components of quality, such as access to care, and examines geographic variation. The disparities report analyzes racial, ethnic, and socioeconomic variation in the same measures of access to care as the quality report and focuses on variation across populations. The reports provide data on a broad set of measures from many databases related to prevention, acute care, chronic disease management, hospitals, doctors' offices, emergency departments, outpatient departments, nursing homes, home health, and hospices.

Disparities are defined as statistically significant differences between two populations with respect to race, ethnicity, income, education, or insurance category. On this basis, AHRQ has found that disparities in quality of care and access to care are common. The reports also utilize statistical methods to track trends over time periods of at least four years. These analyses indicate that about two-thirds of the quality of care measures being tracked are improving over time across different populations of race, ethnicity, and socioeconomic status. The measures are split about evenly between process measures and outcome measures; all measures are made at the level of the individual rather than the community. Measures related to issues within institutions, such as hospitals and nursing homes, are improving faster than measures related to diabetes care or maternal and child health where it may be more difficult to affect change. Improvements in quality of care within each population have generally not translated into reduction of disparities between populations. Examples of disparities getting worse over time include diabetes care, colorectal cancer screening, and general cancer screening.

Benchmarking methodology is applied to both reports based on state variations. Average data from the top 10 percent (i.e., top five states) are noted as a target for everyone. For example, in 2008, the top states had colorectal cancer screening rates around 68 percent, although rates varied across populations on the basis of race, ethnicity, and income. AHRQ calculates that the Asian population will not reach the benchmark rate for another 10 to 15 years, and the low income population may not reach it for 30 years.

The Council discussed how the data in these reports could be used to create policy or address resource allocation issues. Council members recommended that AHRQ include data from U.S. territories to the extent possible and indicate when data are not available from those locations.

Dr. Moy noted that AHRQ works closely with many states that are interested in the findings of the reports. The reports provide many tables and web-based tools that allow each state to see how it is performing on the measures compared to other states. The national healthcare reports, data, and tools can be accessed at: www.ahrq.gov/research/findings/nhqdr/index.html

PUBLIC COMMENTS

In response to a Federal Register announcement, a member of the public commented on the transparency of NACMHD meetings. In addition, Dr. Marjorie Mau submitted a comment voicing her appreciation for the opportunity to serve as a Council member.

CLOSING REMARKS

In closing, Dr. Ruffin commented that one of the most important items coming up for the Institute and the Council is the development of the NIH health disparities strategic plan, which should utilize available data, such as the data reported in the national healthcare reports to support the agency's strategic direction for health disparities. Dr. Ruffin thanked Council members and NIMHD staff for their efforts on behalf of the Institute.

ADJOURNMENT

Ms. Brooks adjourned the 33rd NACMHD meeting at 3:38 p.m.

We hereby certify that, to the best of our knowledge, the foregoing minutes are accurate and complete.

/ John Ruffin /

John Ruffin, Ph.D., Director, National Institute on Minority Health and Health Disparities, NIH

/ Donna A. Brooks /

Donna A. Brooks, Executive Secretary, National Institute on Minority Health and Health Disparities, NIH